World Chronicle

UNITED NATIONS

PROGRAMME: No. 770 recorded 3 December 1999

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HIV/AIDS

According to new estimates from UNAIDS and the World Health Organization, almost 34 million people around the world will be living with AIDS by the beginning of the year 2000. These millions of men, women and children will face a future dominated by a fatal disease unknown just a few years ago. In this edition of **World Chronicle**, Dr. Lindsay Edouard, Senior Reproductive Health Officer at the United Nations Population Fund, discusses preventive measures that are being taken globally in order to control the spread of the aids epidemic.

WORLD CHRONICLE is produced by the Media Division, Department of Public Information, United Nations, New York, NY 10017, U.S.A.

Duration: 28:00"
Executive Producer: Chaim Litewski
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ANNOUNCER: From United Nations Headquarters in New York, this is **World Chronicle**, an unedited interview programme about major global issues.

Here now to introduce our guest is the host of today's **World Chronicle**.

LITTLEJOHNS: I'm Michael Littlejohns, and this is **World Chronicle**.

More than 2.6 million people worldwide died from AIDS in 1999. This is the highest number since the epidemic began and the death toll is set to rise in the new millennium. Since the beginning of the AIDS epidemic in 1981, a staggering 50 million people have become infected. The recently released AIDS Epidemic Update, produced by the Joint United Nations Programme on HIV/AIDS, UNAIDS, and the World Health Organization, paints a grim picture of the future. This is particularly true for those living in developing countries, where the overwhelming majority of people with HIV – some 95 percent of the global total – live. Can anything be done to stop the spread of this killer disease, especially in developing countries?

Our guest today is an expert on public health. He is Dr. Lindsay Edouard, Senior Reproductive Health Officer with the United Nations Population Fund. Joining me to talk with Dr. Edouard are Minh Vo of *The Christian Science Monitor* and Robert Holloway from *Agence France-Presse/AFP*.

Dr. Edouard, welcome to **World Chronicle.**

Doctor, the perception, I think, in the United States, unless I'm mistaken, is that the epidemic is not quite as bad as it was. People are surviving longer. There have been cases of people who seem almost to be in remission. Yet, as we just said, 2.6 million people – it's a record – died throughout the world during 1999. Is this because in developing countries there is not the capability to do the kind of interventions that are possible with new drugs, new systems of care that prevail in the developed countries?

EDOUARD: Part of the problem is the lack of resources and what we should do in the first place is to make sure that we know what are the effective interventions and make sure that we do implement them properly. So part of the problem would be how health services are organized, and also prevention. We need political commitment, we need advocacy to make sure that that disease gets to the top of the agenda when the Ministry of Health or other ministries that can do something have to take decisions. And here we should say that we should not only emphasize what goes on in the medical field or in the health field because there are many other interventions that go on outside those fields which can

help in order to control the disease.

LITTLEJOHNS: The African countries have been particularly badly affected by the pandemic -- Uganda, Botswana, Kenya, South Africa to name just a few. Aren't these countries giving sufficiently high priority to the problem?

EDOUARD: We have seen in some of those countries great priority given to the disease and that has been reflected in the monitoring process. If you see what percentage of pregnant women are carrying the HIV virus, you do see recently a decrease in the incidence of HIV which means that what was happening a few years ago is partly under control. But there is a long way to go before we can control the disease fully.

VO: In the most recent report issued by UNAIDS it says more women in Africa are HIV infected than men and is this true for just Africa or is it a phenomenon that you could see in other regions as well?

EDOUARD: This was a very interesting finding and we think it reflects the conditions in Africa whereby the disease is transmitted mainly through the heterosexual process. What is even more interesting to note is that in Africa, quite often, the incidence of HIV among girls in their late teens, early twenties, is about six times that in boys and what we think is happening here is that although the men had a lead in the first place in getting the HIV virus, it has been transmitted to their partners who are much younger. And that's how, unfortunately, the adolescent girls have gotten infected very quickly.

HOLLOWAY: You mentioned pregnant women could you explain to us, as a doctor, the mechanism, the transmission of HIV virus from a pregnant woman to a child and also the transmission from a mother to a small child. What kind of drugs can be used to impede this transmission?

EDOUARD: Of course HIV is transmitted mainly through body fluids and in the case of the fetus who is in contact with the mother, we have to be very careful in order to assess the various ways in which that transmission can occur. And at the time of delivery, you have all kinds of body fluids, like the amniotic fluid and blood that can cause infection, and after delivery, you have also the case of breast milk. And here I do not want to cause any major controversy regarding breastfeeding. I should state, first of all, that breastfeeding is something we should encourage. It's very good for the child but in the case of a mother who is HIV positive, there are certain precautions that should be taken and each case should be assessed individually.

LITTLEJOHNS: Dr. Edouard, you mentioned these body fluids and of course the fluids that flow when a child is born. Many children in developing countries are born without medical assistance in that, or at least in the same sense that it's available in countries like the United States or those of Europe. Are midwives and others very much at risk in such situations?

EDOUARD: We should think not only of HIV but also of other infections. A basic principle of any surgical procedure -- and by surgical I include a normal delivery in it -- is to make sure that we use proper aseptic procedures so that we are there not to prevent just HIV but to prevent other infections as well. Therefore, I am pretty certain that the midwives and other health workers who are assisting at delivery are aware of the need for those precautions. Now to what extent these precautions are going to be taken in a practical case is a different matter. It might well depend on the availability of surgical gloves, on the availability of other conditions of that environment that would promote a truly aseptic procedure.

LITTLEJOHNS: So this could be a contributory factor to the spread of the disease?

EDOUARD: It could will be.

LITTLEJOHNS: A lot of poor countries, they simply do not have these facilities.

EDOUARD: Indeed. And you also have to think about how instruments are sterilized, to what extent an instrument is used on one patient and immediately being used on someone else and also the safety of the blood supplies.

HOLLOWAY: I believe that studies have indicated that the risk of transmission at the moment of delivery can be greatly reduced if delivery is by caesarian section. Is that correct?

EDOUARD: Yes, indeed that has been shown to be the case but I would not promote caesarian section in any circumstance just for that reason whatsoever. I think we should look at the whole health care delivery system and see to what extent certain procedures can be implemented on that and we should think also, not only of safety for the child, but also for the safety for the mother. There are certain risks associated with caesarian sections, there are certain benefits associated with it and it is very difficult sometimes to take a global solution to the problem. And I would say that the best thing is for the health care providers to assess the case of each individual person in the place itself in order to see what

is best.

VO: I just want to clarify something you said earlier. Would you recommend that a person who is HIV positive not breastfeed their child and use formula instead?

EDOUARD: I think that here again it depends on the individual situation of the person. If you are HIV positive and you do have all the facilities to have clean water, to have formula, you can buy the formula, make it properly, in your case that might be fine. But in the case of someone who does not have enough money to buy formula, who does not have easy access to clean water, it's quite a different situation. Therefore, I would rather put the facts on the table and let a decision be taken. Now you are going to ask me how can a poor mother living in a rural area in a poor country take that decision? And here again, if we come back to the health care system where I think the health providers are in a very good position to provide the information and finally help come to a final decision, that would be the best for mother and baby.

HOLLOWAY: In some countries, it's if not compulsory, at least routine, to screen pregnant women of a certain age for Down's Syndrome, toxoplasmosis, for syphilis and so on. Is there any objection – or I'm sure there are objections to mandatory screening of HIV?

EDOUARD: In public health usually we're against mandatory of anything but in the case of HIV and pregnancy, I would say that since we have certain interventions that are effective in order to prevent transmission to the baby, a very good case can be made for testing for HIV during the ante-natal period. And, I think, if you provide the mother with the right information and counselling she's likely to come up with the right decision and want the HIV testing. I would rather use that approach instead of having a mandatory approach followed by uncooperation on the part of the woman. I think once she's had the testing and then if she's positive she could be advised on the various alternatives that can be taken. I'm pretty sure that would be the right way to go.

HOLLOWAY: You said that there are effective procedures for impeding the transmission, I think you could quite give small doses of AZT which are made immediately before before delivery and shortly afterwards, can be done cheaply. Is that correct?

EDOUARD: There has been a lot of progress in that field over the last 12 months or so and there are other alternative drugs also coming into the picture now and the whole thing is currently being debated. Trials are being held therefore all I would like to

say is that, yes, there is a way of doing it. There are certain drugs that can be used but more needs to be done in order to find out the actual drug or drugs that are going to be recommended, in what dosage and also where. Because in some countries the cost of the drugs is so high that they are not really accessible to most of the population. But for sure we have ways of intervening in that area now and ways that were not possible years a few back.

LITTLEJOHNS: This is **World Chronicle**. Our guest is Dr. Lindsay Edouard, Senior Reproductive Health Officer with the United Nations Population Fund.

Dr. Edouard, looking ahead you, as an expert in the field, and your colleagues, what is your prognosis for this terrible disease? Do you think that within perhaps the next decade, the first decade of the new millennium, it's going to be licked?

EDOUARD: Well, I have to be a bit pessimistic in that sense if we're thinking about a vaccine. There's a lot of work going on in order to find a vaccine but personally I don't see a vaccine being available on the market in the next five or six years. Maybe not even in the next ten years. But let's hope maybe it will be available but at this stage, I don't think it's a feasible option. Therefore, I think that the best way is to go for prevention in the first place, and for those cases that we have not been able to prevent we have to find some way of treating the individuals affected by using drugs, etc. And also we should not forget about their families and all the orphans in the world today who have lost both parents to AIDS.

LITTLEJOHNS: Have there been actual cases of real cures -- people who have survived five years, ten years perhaps free of the disease?

EDOUARD: Like cancer, I would say that we can talk of cure but in the long term it's difficult to actually believe that it was a cure and in fact with the drugs in the market now in some countries, those who are in remission feel that they have been cured and therefore become more complacent. And that's a very big problem because by being complacent, what they are doing is in fact they may spread the disease to more people.

LITTLEJOHNS: Not using condoms, for example?

EDOUARD: Exactly. That's what I'm thinking of.

VO: Given that infections have continued unabated and 1999 was a year for deaths due to HIV, is there any reason to be optimistic at all?

EDOUARD: In certain countries where we have seen a decrease in the incidence of new infections amongst the adolescents or among young pregnant women, that

gives us a lot of hope and belief that interventions can work when they're implemented properly.

VO: Which countries are these?

EDOUARD: Oh in Uganda, for example, where we have seen a decrease in the rate of new infections among pregnant women.

HOLLOWAY: The report suggested that in some conservative countries in the Middle East and in the South Pacific that the reporting of sexually transmitted diseases is very, very low. I think six percent of cases are estimated to being reported. Could this suggest that in some parts of the world that the estimate of HIV infection is in fact too low?

EDOUARD: Well, I would say in just about every country in the world, the reporting of sexually transmitted diseases is likely to cause problems. And that affects not only sexually transmitted diseases but other diseases as well. Because when a health care provider sees a patient, the main interest here is to treat that patient whereas the actual reporting becomes secondary. Therefore, whether it's a case of measles in a child or sexually transmitted disease in an adult man, there is likely to be under-reporting. But in certain countries, for sure, there is major, major under-reporting and that's where we might have the wrong picture of the problem. And in the case of HIV/AIDS that becomes even more serious because the spread of sexually transmitted disease is a good indicator of what is likely to come along a few years later as far as HIV and AIDS is concerned, and that becomes worst when this is happening amongst adolescents because the spread is even more rapid and then you're likely to get HIV/AIDS in teenagers and youth – those who are less than 25 years old. And that's when you get the major problems. So the best thing is to accept that there is a problem in the first place and treat the sexually transmitted diseases in order to prevent HIV later on. And we do know that individuals who have a sexually transmitted disease have a risk which is about eight times higher for HIV.

VO: You are a doctor, you're an obstetrician and a gynaecologist. In the United States a lot of attention is given to a movement called Women's Health. Is there a difference between women's health and reproductive health and for the problem of HIV prevention, what is the better approach?

EDOUARD: Well, in reproductive health, we try to see all the problems associated with reproduction and as part of that we look after pregnancy, we look after complications of pregnancy and delivery, sexually transmitted disease, other diseases of the

reproductive tract such as cervical cancer and also those harmful practices for the health of women. And if you think in the first place of HIV, you might think that it is a sexually transmitted disease therefore the reproductive health approach is a good one, for sure. But we believe in an intersexual approach because there is more than that that can affect sexually transmitted diseases, including HIV/AIDS. Therefore, we believe a lot in the empowerment of women and the status of women. Therefore what we are doing really in reproductive health is to look at all the problems of women, in which case I would say that yes, you can look at it as woman's health with a specialization in reproductive health.

LITTLEJOHNS: Dr. Edouard, you've laid considerable emphasis on prevention can you perhaps spell out for us -- A, B, C, D -- steps that men and women should take preventatively hopefully to avoid, especially if they are at risk, to avoid contracting HIV?

EDOUARD: In the first place, we should think about all the possible ways that it can be contracted and therefore think about the prevention that can go with it. And in the case of teenagers, we have always believed in delaying the age at first intercourse using abstinence as necessary. And for those adolescents who are going to have sexual intercourse they should for sure use a method like a male condom that will prevent infection, and also now we have female condoms as well which can be used, and there should be HIV testing that is available for those who are at risk who want to know their status and take adequate precautions as well. And as far as family planning methods, we have been thinking for a long time about getting a method that is microcidal, in the sense that microbes will be killed, and up to now we have not come up with the correct method. But we hope again that in a few year's time we will have a family planning method that will include microbicides so that we can prevent HIV transmission that way.

LITTLEJOHNS: Females seem to be maturing sexually at a much younger age than used to be the case is this also a factor in the increase in AIDS?

EDOUARD: That's possible because the mucosa of the vagina at an early age is likely to be more fragile and once you get into contact with body fluids -- with t semen -- it's quite likely that the HIV virus would be transmitted easier that way.

VO: Can you tell us about some of your work overseas or are there any governments who are more receptive than others, who are more helpful than others, who are not really not willing to listen to what you have to say or resistant to your public health suggestions?

EDOUARD: Of course, no two governments are going to be the same and therefore the way policies are accepted or implemented in different countries would be very different. But what matters more is not actually to be receptive to what we want to discuss, we want to propose but also transform them into policies and be able to convert these policies into actual action that can reach the populations. And this is easier said here today than done out there in any country because in every single country these days, we have limited resources for health care and that's why I wanted to make sure that it's one thing that is very important is to make sure that whatever we do, whenever we intervene, that we are intervening for the right reason and make sure it is effective. There's no reason in the year 2000 for interventions to be ineffective in the first place.

LITTLEJOHNS: Is the sharing of needles and general drug injecting less of a factor in the incidence of HIV/AIDS now than perhaps it used to be in the past because judging from what you have been telling us on this programme, it seems that heterosexual sex is contributing more to the problem now than for example gay sex. And you have not said too much about injected drugs.

EDOUARD: Well, that's not really true because in some parts of the world, in Asia, for example, sharing of needles is a problem and that we are getting more and more cases from intravenous drug users.

VO: For a place like the former countries of Soviet Union where intravenous drug use is probably main the reason for the sharp increase in HIV infection, what kind of preventive measures would you recommend? Would you recommend passing out clean needles to people?

EDOUARD: I think experience in North America over the last decade or so has shown that the provision of clean needles associated with health education and associated services has been of greater value in order to decrease the incidence of HIV. And I think there's a lot to be said for collaboration between countries in order to share experiences, for health providers to have visits overseas to be able to meet those other health providers in order to get first hand information and be able to go on and adopt that experience for their own countries.

HOLLOWAY: On the question of education, how serious a problem is superstition in third world countries?

EDOUARD: Myths have always prevailed in health care. In whatever part of

health care that you dare to think about, you will see that there are various myths and in the case of HIV, because it's a relatively new disease, there have been also myths about it and it's very difficult to dispel the myth and even today, those myths still, unfortunately, do persist. And that's why we need to have proper health education and advocacy with the decision makers in government so that HIV/AIDS can get the right priority in their circles.

LITTLEJOHNS: Switching from superstitions to cultural problems, there's a lot of resistance to the use of condoms in many cultures is this becoming an obstacle for you people in the Population Fund who advocate so strongly the use of condoms?

EDOUARD: We have had our problems with advocacy of male condoms but now we have even moved forward and we see more and more requests for supplies and supplies are being used properly. And now we are moving even into female condoms and there's a great demand for even female condoms now, already. And, therefore, I feel very confident that the objections to the use of condoms and the myth about the value of condoms for the prevention of HIV, I feel that this is behind us now.

LITTLEJOHNS: AIDS is a fairly recent health problem. We mentioned in the introduction that, I think, 1981 saw the beginning of a serious problem. Where did this terrible thing originate? There have been various theories about the Congo have you guys been able to come up with some very serious information on the origins of the disease?

EDOUARD: Not yet. It's a fascinating story. It was a surprise when the disease was first recognized and I think when doctors of my age think back to our own practices in the '70s, we can think of individual patients we looked after that we had no diagnosis – patients who died. And now, in retrospect, we think about them and say maybe that one, or this one, was a case of AIDS.

LITTLEJOHNS: Even before 1981?

EDOUARD: Even before 1981. But we think about it, we have no diagnosis ourselves, but we think of those cases that were special cases with special features and we're still hearing of various theories about the origins of the disease. And I think we have to wait a few more years to get the whole story.

LITTLEJOHNS: Dr. Edouard, that's all the time we have. Thank you for being with us on this edition of **World Chronicle**.

Our guest has been Dr. Lindsay Edouard, Senior Reproductive Health Officer with the United Nations Population Fund. He was interviewed by Minh Vo of *The Christian*

Science Monitor and Robert Holloway from *Agence France-Presse/AFP*.

I'm Michael Littlejohns. Thank you for joining us. We invite you to be with us for the next edition of **World Chronicle.**

ANNOUNCER: Transcripts of the programme may be obtained free of charge by sending a stamped, self-addressed envelope to **World Chronicle**, United Nations, Room S-827, New York, N.Y., 10017.

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